

LOUISIANA PATIENTS' COMPENSATION FUND
SELF INSURED HEALTHCARE PROFESSIONAL APPLICATION

DATES OF ENROLLMENT APPLYING FOR: _____

I, _____, _____, am licensed
 (First name, middle name and last name) (Prof. Degree)

to provide professional medical services as a _____.
 (Specialty or designation)

LICENSE NUMBER: _____ **DATE OF BIRTH** _____

Do you work part time? _____ Number of hrs/week? _____ **Complete Form PCF12**

RENEWAL APPLICATIONS ONLY: I hereby certify that there have been no changes in any aspect addressed by this form since my last completed application to the LA PCF **especially in regards to questions number 10, 11 and 12;** and, I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution: _____.

 Signature

 Date

1. Office Address (no P.O. Box): _____

 City _____ Parish _____

State/Zip _____ Telephone _____

Email Address: _____

2. Home Address _____

3. Professional degree from _____

County _____ Degree _____ Year _____

4. Internships and Residencies (dates, services & locations):

5. Present Specialty _____ Sub-specialties _____

Board Certified _____

6. Local professional society _____
7. Staff privileges at _____
8. Name of previous professional liability carrier _____
9. I am not employed by any physicians group, firm, hospital or corporation except as follows: (if no exception, so state)

10. Do you or your medical partnership or corporation with which you are professionally involved with employ any of the following: Licensed Physician Assistants, Licensed Nurse Practitioners, CRNAs, Nurse Midwives, and/or Surgical Assistants or Pharmacists? **If yes, and you wish to provide coverage through your self insurance, please list their names and include the appropriate surcharge for each.**

11. List names of any partners (if applicable): _____

12. Are you a stockholder in a professional medical corporation? **If yes, you must complete the corporation application (PCF9) from our website and return it with your payment.**

Name of corporation/partnership/LLC/LLP _____

13. Please indicate answers to questions below. Fully explain any "yes" answer in space allowed.

- a.** Do you practice medicine outside of Louisiana?
- b.** Do you provide care at a Correctional Institute?
- c.** Has membership in any professional association or society ever been revoked?
- d.** Has any hospital suspended, restricted or refused you staff privileges?
- e.** Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?
- f.** Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?
- g.** Have you ever been treated for alcoholism, narcotic addiction or mental illness?
- h.** Have you ever been convicted of a crime?

YES	NO

- i. Have you ever had any chronic illness or physical defect?
- j. Have you ever had any professional liability insurance refused, cancelled or non-renewed?
- k. Do you work in any emergency room or industrial medical facility?
- l. Do you own, operate or supervise the operation of any hospital or sanitarium?
- m. Have any claims or suits been filed against you during the past 5 years as a result of professional services rendered?
- n. Are you employed by a facility as a Medical Director?

Details on "yes" answers (please identify by letter): _____

14. Please indicate which of the following medical/surgical procedures you engage in:

Accupunture	Gynecology	Open spinal procedures (non-diagnostic)
Administer general anesthesia	Gynecology-surgery	Ophthalmology Surgery
Anesthesiology	Hand Surgery	Orthopedic Surgery w/spine
Angiography	Hematology	Orthopedic Surgery-no spine
Appendectomies	Hemorrhoidectomies	Orthopedic – Minor Surgery
Assist in surgery	Hysterectomies	Otorhinolaryngology
Cardiac catheterization	Intensive Care Medicine	Pathology
Cardiac Surgery	Internal Medicine	Pediatrics
Cardiovascular Diseases	Internal Medicine-surgery	Physiatry or Physical Medicine & Rehab
Cardiovascular Surgery	Laser Procedures	Plastic Surgery
Cesarean sections	Major surgery in E.R.	Psychiatry
D & Cs / Abortions	Needle Biopsies	Saddle blocks
Dermabrasions	Neonatology	Spinal anesthetics/Epidural
Dermatology	Nephrology	T & A's
Electroshock therapy	Neurology	Telemedicine
Emergency Medicine	Neurosurgery	Thoracic Surgery
Family Practice	Obstetrical deliveries	Traumatic Surgery
Family Practice-surgery	Obstetrics	Tubal ligations
Gastroenterology	Obstetrics/Gynecology	Urological Surgery
General Practice	Occupational Medicine	Vascular Surgery
General Practice-surgery	Office x-rays	Vasectomies
General Surgery	Open reductions of fractures	Weight control (other than diet)

15. Do you perform x-ray or other radiation therapy? _____

If so, please list x-ray technicians employed by you: _____

Radium technicians employed by you: _____

16. Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets forth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation and termination of enrollment with the Patient's Compensation Fund for failure to comply with these reporting requirements.

INCLUSIONS:

Employed allied healthcare providers. This does not include those who require a PCF surcharge, such as, MD's, NP's, PA's, CNS', CRNA's, etc.

PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

- (1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
- (2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.
- (3) Services or treatment rendered as a licensed provider in states other than Louisiana.

SIGNED: _____ **DATE:** _____